

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Sheris Marita Gafford
10210 Basalt Lane
Mentone, CA 92359

Case No. 2008-49

Registered Nurse License No. 468446

Respondent

DECISION AND ORDER

The foregoing Stipulated Settlement for Public Reprimand is hereby adopted as the Decision and Order of the Board of Registered Nursing, Department of Consumer Affairs. A letter of public reprimand shall issue from the Executive Officer of the Board of Registered Nursing.

This Decision shall become effective on June 5, 2009.

IT IS SO ORDERED May 5, 2009.

Susanne Phillips, MSN, RN, FNP-BC
President
Board of Registered Nursing
Department of Consumer Affairs
State of California

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 GLORIA A. BARRIOS
Supervising Deputy Attorney General
3 SCOTT J. HARRIS, State Bar No. 238437
Deputy Attorney General
4 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
5 Telephone: (213) 897-2554
Facsimile: (213) 897-2804
6

7 Attorneys for Complainant

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 SHERIS MARITA GAFFORD
10210 Basalt Lane
Mentone, CA 92359

14 Registered Nurse License No. 468446

15 Respondent.

Case No. 2008-49

OAH No. L2008100283

16 **STIPULATED SETTLEMENT FOR**
17 **ISSUANCE OF PUBLIC**
18 **REPRIMAND**

19 In the interest of a prompt and speedy settlement of this matter, consistent with the
20 public interest and the responsibility of the Board of Registered Nursing of the Department of
21 Consumer Affairs, the parties hereby agree to the following Stipulated Settlement for Issuance of
22 Public Reprimand, which will be submitted to the Board for approval and adoption as the final
23 disposition of the Accusation.

24 **PARTIES**

25 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) is the Executive Officer of
26 the Board of Registered Nursing. She brought this action solely in her official capacity and is
27 represented in this matter by Scott J. Harris, Deputy Attorney General, and Kimberley J. Baker-
28 Guillemet, Deputy Attorney General for Edmund G. Brown Jr., Attorney General of the State of
California.

///

1 2. Sheris Marita Gafford (Respondent) is represented in this proceeding by
2 attorney Paul Spackman, whose address is:

3 Iungerich & Spackman
4 28441 Highridge Rd #201
5 Rolling Hills Est, CA, 90274-4869

6 3. On or about August 31, 1991, the Board of Registered Nursing issued
7 Respondent Registered Nurse License No. 468446. The license was in full force and effect at all
8 times relevant to the charges brought in Accusation No. 2008-49 and will expire on January 31,
9 2009, unless renewed.

10 JURISDICTION

11 4. Accusation No. 2008-49 was filed before the Board of Registered Nursing
12 (Board), Department of Consumer Affairs, and is currently pending against Respondent. The
13 Accusation and all other statutorily required documents were properly served on Respondent on
14 August 23, 2007. Respondent timely filed her Notice of Defense contesting the Accusation. A
15 copy of Accusation No. 2008-49 is attached as Exhibit A and incorporated herein by reference.

16 ADVISEMENT AND WAIVERS

17 5. Respondent has carefully read, fully discussed with counsel, and
18 understands the charges and allegations in Accusation No. 2008-49. Respondent has also
19 carefully read, fully discussed with counsel, and understands the effects of this Stipulated
20 Settlement and Disciplinary Order.

21 6. Respondent understands and agrees that this Stipulated Settlement for
22 Issuance of Public Reprimand, and corresponding Letter of Public Reprimand are final and may
23 not be challenged or appealed.

24 7. Respondent is fully aware of her legal rights in this matter, including the
25 right to a hearing on the charges and allegations in the Accusation; the right to be represented by
26 counsel at her own expense; the right to confront and cross-examine the witnesses against her;
27 the right to present evidence and to testify on her own behalf; the right to the issuance of
28 subpoenas to compel the attendance of witnesses and the production of documents; the right to

1 reconsideration and court review of an adverse decision; and all other rights accorded by the
2 California Administrative Procedure Act and other applicable laws.

3 8. Respondent voluntarily, knowingly, and intelligently waives and gives up
4 each and every right set forth above.

5 CULPABILITY

6 9. Respondent understands the nature of the charges alleged in Accusation
7 No. 2008-49 and agrees that, if proven, such charges would constitute cause for imposing
8 discipline upon her Registered Nurse License.

9 10. For the purpose of resolving the Accusation without the expense and
10 uncertainty of further proceedings, Respondent hereby gives up her right to contest those charges
11 and agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary
12 Order below.

13 RESERVATION

14 11. The admissions made by Respondent herein are only for the purposes of
15 this or any other proceeding in which the Board of Registered Nursing or other professional
16 licensing agency is involved, and shall not be admissible in any other criminal or civil
17 proceeding.

18 CONTINGENCY

19 12. This stipulation shall be subject to approval by the Board of Registered
20 Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the
21 Board of Registered Nursing may communicate directly with the Board regarding this stipulation
22 and settlement, without notice to or participation by Respondent. By signing the stipulation,
23 Respondent understands and agrees that she may not withdraw his agreement or seek to rescind
24 the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt
25 this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall
26 be of no force or effect and, except for this paragraph, it shall be inadmissible in any legal action
27 between the parties, and the Board shall not be disqualified from further action by having
28 considered this matter.

13. The parties understand and agree that facsimile copies of this Stipulated Settlement for Issuance of Public Reprimand, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 468446 issued to Respondent Sheris M. Gafford shall be publically reprimanded by way of letter from the Executive Officer pursuant to Business and Professions Code section 495. The Letter of Public Reprimand will issue as set forth above and shall be in the same form as the letter attached as Exhibit B.

ACCEPTANCE

I have carefully read the Stipulated Settlement for Issuance of Public Reprimand. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Settlement for Issuance of Public Reprimand voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 1/22/09


SHERIS MARITA GAFFORD
Respondent

\\

\\

\\


\\

\\

\\

1 I have read and fully discussed with Respondent Sheris Marita Gafford the terms
2 and conditions and other matters contained in the above Stipulated Settlement for Issuance of
3 Public Reprimand. I approve its form and content.

4 DATED: Jan. 22, 2009

5
6 
7 PAUL SPACKMAN
8 Attorney for Respondent

9 ENDORSEMENT


10 The foregoing Stipulated Settlement for Issuance of Public Reprimand is hereby
11 respectfully submitted for consideration by the Board of Registered Nursing of the Department of
12 Consumer Affairs.

13
14 DATED: 1/22/09

15 EDMUND G. BROWN JR., Attorney General
16 of the State of California

17 GLORIA A. BARRIOS
18 Supervising Deputy Attorney General

19 KIMBERLEY BAKER-GUILLEMET
20 Deputy Attorney General

21 
22 SCOTT J. HARRIS
23 Deputy Attorney General

24 Attorneys for Complainant

25 DOJ Matter ID: LA2006601493
26 60371152.wpd
27
28

Exhibit A
Accusation No. 2008-49

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 MARC D. GREENBAUM, State Bar No. 138213
Supervising Deputy Attorney General
3 JAMI L. CANTORE, State Bar No. 165410
Deputy Attorney General
4 California Department of Justice
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-2569
6 Facsimile: (213) 897-2804

7 Attorneys for Complainant

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2008-49

13 SHERIS MARITA GAFFORD
10210 Basalt Lane
Mentone, CA 92359

A C C U S A T I O N

14 Registered Nurse License No. 468446

15 Respondent.

16
17 Complainant alleges:

18 PARTIES

19 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation
20 solely in her official capacity as the Executive Officer of the Board of Registered Nursing,
21 Department of Consumer Affairs.

22 2. On or about August 31, 1991, the Board of Registered Nursing issued
23 Registered Nurse License No. 468446 to Sheris Marita Gafford (Respondent). The Registered
24 Nurse License was in full force and effect at all times relevant to the charges brought herein and
25 will expire on January 31, 2009, unless renewed.

26 JURISDICTION

27 3. This Accusation is brought before the Board of Registered Nursing
28 (Board), Department of Consumer Affairs, under the authority of the following laws. All section

1 references are to the Business and Professions Code unless otherwise indicated.

2 STATUTORY PROVISIONS

3 4. Section 2750 of the Business and Professions Code (Code) provides, in
4 pertinent part, that the Board may discipline any licensee, including a licensee holding a
5 temporary or an inactive license, for any reason provided in Article 3 (commencing with section
6 2750) of the Nursing Practice Act.

7 5. Section 2764 of the Code provides, in pertinent part, that the expiration of
8 a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding
9 against the licensee or to render a decision imposing discipline on the license. Under section
10 2811(b) of the Code, the Board may renew an expired license at any time within eight years after
11 the expiration.

12 6. Section 2761 of the Code states:

13 "The board may take disciplinary action against a certified or licensed nurse or
14 deny an application for a certificate or license for any of the following:

15 "(a) Unprofessional conduct, which includes, but is not limited to, the following:

16 "(1) Incompetence, or gross negligence in carrying out usual certified or licensed
17 nursing functions.

18
19 "(d) Violating or attempting to violate, directly or indirectly, or assisting in or
20 abetting the violating of, or conspiring to violate any provision or term of this chapter [the
21 Nursing Practice Act] or regulations adopted pursuant to it."

22 7. California Code of Regulations, title 16, section 1442, states:

23 "As used in Section 2761 of the code, 'gross negligence' includes an extreme
24 departure from the standard of care which, under similar circumstances, would have ordinarily
25 been exercised by a competent registered nurse. Such an extreme departure means the repeated
26 failure to provide nursing care as required or failure to provide care or to exercise ordinary
27 precaution in a single situation which the nurse knew, or should have known, could have
28 jeopardized the client's health or life."

1 8. California Code of Regulations, title 16, section 1443, states:

2 "As used in Section 2761 of the code, 'incompetence' means the lack of possession
3 of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed
4 and exercised by a competent registered nurse as described in Section 1443.5."

5 9. California Code of Regulations, title 16, section 1443.5 states:

6 "A registered nurse shall be considered to be competent when he/she consistently
7 demonstrates the ability to transfer scientific knowledge from social, biological and physical
8 sciences in applying the nursing process, as follows:

9 "(1) Formulates a nursing diagnosis through observation of the client's physical
10 condition and behavior, and through interpretation of information obtained from the client and
11 others, including the health team.

12 "(2) Formulates a care plan, in collaboration with the client, which ensures that
13 direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and
14 protection, and for disease prevention and restorative measures.

15 "(3) Performs skills essential to the kind of nursing action to be taken, explains
16 the health treatment to the client and family and teaches the client and family how to care for the
17 client's health needs.

18 "(4) Delegates tasks to subordinates based on the legal scopes of practice of the
19 subordinates and on the preparation and capability needed in the tasks to be delegated, and
20 effectively supervises nursing care being given by subordinates.

21 "(5) Evaluates the effectiveness of the care plan through observation of the
22 client's physical condition and behavior, signs and symptoms of illness, and reactions to
23 treatment and through communication with the client and health team members, and modifies the
24 plan as needed.

25 "(6) Acts as the client's advocate, as circumstances require, by initiating action to
26 improve health care or to change decisions or activities which are against the interests or wishes
27 of the client, and by giving the client the opportunity to make informed decisions about health
28 care before it is provided."

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL SUMMARY

11. Patient D.S., an 80 year old male, was admitted to Kaiser Permanente in Fontana ("Kaiser") on January 17, 2004, for diagnostic surgery on a bifrontal mass following a CT scan. Patient D.S. underwent a left frontal craniotomy with partial excision of a tumor for biopsy and decompression on January 18, 2004.

12. Patient D.S. was admitted to Kaiser with a history of confusion, difficulty walking, incontinence, and slurred speech since approximately late December. Prior to that, he was fully independent, drove, and acted as care giver to his wife.

13. On or about January 18, 2004, at approximately 0530, while in the intensive care unit, Patient D.S. pulled out his breathing tube. At approximately 1600, Patient D.S. was transferred to a surgical floor. Per patient restraint orders, bilateral soft wrist restraints were applied to prevent interfering with dressings and/or devices and pulling out tubes.

14. On or about January 19, 2004, at approximately 0300, Patient D.S. was found out of bed and sitting in a chair. He stated that he wanted to go home. He had pulled out his IV and Foley catheter. He had received a dose of morphine at approximately 1700 for a headache. Patient D.S. was subsequently given a sedative to help prevent him from getting out of bed. Restraints were not utilized on January 19, 2004.

15. On or about January 20, 2004, at approximately 1830, the evening shift RN applied a Posey vest restraint on Patient D.S. after noting that he was confused and tried to get out of bed. The vest was used without a condition-specific order for use. The evening shift RN signed off at 2300 and noted that the vest was off.

16. On or about January 20, 2004, at approximately 2400, Respondent noted that the vest restraint was on Patient D.S. Respondent noted the continued use of the vest from the start of her shift until 0300.

1 17. On or about January 21, 2004, at approximately 0350, Patient D.S. was
2 found on the floor of his room without a pulse and not breathing. The Posey restraint vest was
3 off. Patient D.S. could not be resuscitated. The time of death was recorded at 0417.

4 CAUSE FOR DISCIPLINE

5 (Unprofessional Conduct: Gross Negligence)

6 18. Respondent's license is subject to discipline pursuant to section 2761,
7 subdivision (a)(1), for unprofessional conduct and gross negligence as defined by California
8 Code of Regulations, title 16, sections 1442, 1443, and 1443.5, in that Respondent demonstrated
9 an extreme departure from the standard of care by her repeated failure to provide the requisite
10 degree of nursing care needed to Patient D.S. as follows:

11 (a) Respondent failed to effectively formulate a care plan for Patient D.S. for
12 the prevention of injury in that the restraint vest alone did not meet the patient's degree of need
13 considering his previous dangerous behavior of pulling lines out and getting out of bed,
14 combined with his extreme risk for fall and/or self-injury due to weakness, lack of judgment,
15 disorientation and confusion.

16 (b) Respondent failed to document the following: effective alternatives to the
17 Posey vest restraint for fall prevention such as medication/sedation or a sitter/family member,
18 documentation of offering fluids or a urinal to the patient, documentation to support her report of
19 checking on the patient every 15-20 minutes, documentation that the side rails were up, or a
20 narrative regarding the patient's prior condition and behavior and/or a justification regarding the
21 continued use of the restraint vest only.

22 (c) Respondent altered documentation such that original entries could not be
23 ascertained for the patient's last measured heart rate or for the resuscitation records, which
24 included the time the patient was found, the time the code was called, and the time of the first
25 intervention.

26 (d) Respondent failed to accurately report the disposition of the restraint vest
27 at the time of death.

28 (e) Respondent failed to notify the coroner of the patient's death, which met

1 the criteria for a reportable death.

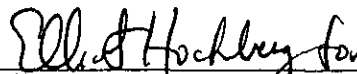
2 (f) Respondent failed to properly apply and use the restraint vest on Patient
3 D.S. in that the patient did not remain in the restraint despite Respondent's self-reported high
4 degree of observation, reorientation and adjustment just prior to the patient being found on the
5 floor of his room. Respondent continued to use the restraint vest without a condition-specific
6 order for use or documentation that the patient's behavior indicated continued use.

7 PRAYER

8 WHEREFORE, Complainant requests that a hearing be held on the matters herein
9 alleged and that, following the hearing, the Board of Registered Nursing issue a decision:

- 10 1. Revoking or suspending Registered Nurse License No. 468446 issued to
11 Sheris Marita Gafford.
- 12 2. Ordering Sheris Marita Gafford to pay the Board of Registered Nursing
13 the reasonable costs of the investigation and enforcement of this case pursuant to Business and
14 Professions Code section 125.3;
- 15 3. Taking such other and further action as deemed necessary and proper.
- 16

17 DATED: 8/14/07

18
19 
20 RUTH ANN TERRY, M.P.H., R.N.
21 Executive Officer
22 Board of Registered Nursing
23 Department of Consumer Affairs
24 State of California
25 Complainant
26
27
28